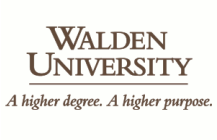

2018

Investigating Relationships Among Counselors' Gender, Race, Multicultural Competency When Counseling Sexual Minorities

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Abstract

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by

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MS, University of Maryland Eastern Shore, 2005

BSW, Salisbury University, 2001

AA, Wor-Wic Community College, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Gay and lesbian individuals are marginalized, stigmatized, and can face bias in the counseling environment. There is a gap in the literature regarding research on gender, race, and multicultural competency and negative racial attitudes towards sexual minorities. This study examined whether multicultural competency (measured by the Multicultural Counseling Knowledge and Awareness Scale) moderates any associations of gender and race with attitudes towards sexual minorities (measured by Attitudes Towards Lesbians and Gay Men Scale) to examine if the role of multicultural competency differs across groups. The sample consisted of 20 White and 14 Non-White participants who were between 30-40 years of age. All counselors were licensed with 3 or more years of experience who held at least a bachelor's degree up to a doctorate. The majority of the counselors who took the survey were mental health counselors, who saw over 20 patients per month. Hierarchical linear regression analysis was conducted to examine the associations among counselors' race, gender, multicultural competency, and attitudes towards sexual minorities. The results of the study indicated that there were no significant effects amongst race, gender, and/or multicultural competency and counselor attitudes. Counselors, gay and lesbian community, and policy makers would benefit from this research. Positive change may result in counselors having a better understanding of diversity, providing a safer environment for sexual minorities, and policy makers can develop new laws. By sharing these results at professional conferences positive social change may result from a supportive environment for sexual minorities seeking counseling.

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Dedication

This dissertation is dedicated to my husband, whose support has been endless. Floyd, I thank you for your emotional and financial support. When I felt like I could not type another word, you were right there to say, you can do it. Your love and confidence in me was endless, and I love you so much. You are the love of my life and I would have never been able to complete this task without you.

To my son, Jordan, there were many times, I could not attend your football games or track meetings due to writing this dissertation. I love the way you always excused me by saying mom it is okay just finish your dissertation so you can do whatever you want to do in life. I would also like to dedicate this dissertation to my mother, Gladys, who has always been my support in all my life decisions. All of you mean so much to me, you always told me to reach for the stars and they could be mine. Your love and support helped me strive to do this dissertation.

Finally, I would like to dedicate this dissertation to my late Pastor Bishop Emanuel C. Baker who died in July 24, 2011. He was my pastor, father, friend, counselor, and mentor. He will be greatly missed as he was instrumental in my life.

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Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction

Introduction

Gay and lesbian people are often stigmatized, criminalized, and ostracized by others (Swank & Raiz, 2007). A report conducted in 1997 by the National Gay and Lesbian Task Force Policy Institute found extensive intolerance of sexual minorities across the country (Swank & Raiz, 2007, 2010). The results of this report indicated that sexual minorities suffered from employment discrimination, discrimination renting a house, discrimination in restaurants, discrimination receiving health services, discrimination obtaining insurance, and discrimination in educational institutions (Swank & Raiz, 2007, 2010). Moreover, hate crimes committed against sexual minorities represent the third-highest classification of crimes reported to the Federal Bureau of Investigation (Swank & Raiz, 2007, 2010).

Sexual minorities face entrenched and longstanding biases in societal systems, and homophobic attitudes remain in the counseling environment (Herek & McLemore, 2013). In general, licensed counselors work with individuals who are undergoing issues due to mental health or behavioral problems (Herek & McLemore, 2013). Counselors are trained professionals who are there to help people and their families as problems arise in their lives (Herek & McLemore, 2013). Counseling is a useful way of aiding clients and counselors can incorporate many different philosophies to help clients emanate resolutions to their problems (Herek & McLemore, 2013). Counseling today is a profession where individuals work in positions such as a social worker, psychologist, career counselor, guidance counselor, school counselor, mental health counselor, or

addiction/substance abuse counselor, and these professionals can assist in helping to promote change in a person's life (Sabin, Riskind, & Nosek, 2015). In the professional counseling environment, same-gender sexual orientations should be given the same due diligence as heterosexual orientations (Sabin et al., 2015). A counselor's ability to provide such services is impeded if the counselor has not first come to terms with his or her own feelings and attitudes about homosexuality (Mize, 2015). An individual's belief system could potentially impede their willingness to advocate on behalf of sexual minorities (Mize, 2015).

In this chapter, I introduced the gaps in the existing literature. The problem statement will be introduced to show why this study was needed. In the purpose of the study section, I will describe the three research questions and hypotheses. The theoretical foundation will be provided so the reader can understand the root of this study. A list of operational definitions will be presented so the reader can relate and understand how terms were used in this study. Lastly, I described the assumptions of the study, the scope, delimitations, and limitations of the study, and the significance of the study.

Background

A counselor's attitude develops from his or her value and belief systems, which can create attitudes towards a client that can influence or change the therapeutic process (Corey, 2009). Negative attitudes toward sexual minorities have been an issue in the counseling field for decades (Fassinger & Richie, 1997; Herek, 2000; LaMar & Kite, 1998). Homophobia incorporates a range of negative attitudes and feelings toward homosexuality or people who are identified or perceived as being lesbian, gay, bisexual,

or transgender (Fassinger & Richie, 1997; Herek, 2000; LaMar & Kite, 1998). Research has shown that race and gender tend to be an issue amongst heterosexual individuals when counseling sexual minorities (Herek, 1998). For example, it has been noted that heterosexual men hold additional and/or extra undesirable attitudes toward sexual minorities when compared to heterosexual women (Herek, 1998).

Effective counseling may be hindered by counselors' homophobic attitudes in the counseling environment and can affect counselors' ability to work with sexual minorities (Balkin, Schlosser, & Levitt, 2009; Israel & Selvidge, 2003; Rainey & Trusty, 2007). When counselors are biased, their negative attitudes towards this group tend to hinder their ability to effectively diagnose, intervene, and/or plan discharge (Swank & Raiz, 2010). Counselors with homophobic attitudes may be dismissive of their sexual minority clients' concerns, resulting in referral to another counselor or premature discharge (Swank & Raiz, 2010). Moreover, additional treatment that may be necessary for the client may be overlooked or ignored (Swank & Raiz, 2010). However, the therapeutic process may change when training is made available to counselors because it affords different models of therapy and counselors learn a variety of counseling styles to better assist clients (Beckstead & Israel, 2007). Also, educational curricula can help specialists to distinguish between their individual philosophies about sexual orientation and their professional accountability to serve the needs of all clients despite sexual preference (Corey, 2009).

To provide effective counseling to sexual minorities, the skill of multicultural competency needs to be acquired (Aarredondo et al., 1996; Bidell, 2005; Israel, Ketz,

Detrie, Burke, & Shulman, 2003). Multicultural competency signifies a set of behaviors, viewpoints, and guidelines amongst professionals, which enable counselors to work effectively with clients regardless of race, gender, or ethnicity (Stuart, 2004). It is equally important for a counselor to become multiculturally aware to comprehend and work with people of other beliefs (Stuart, 2004). When a counselor can gain greater self-awareness, improve interpersonal skills, lessen and reduce their stereotypes of certain groups, then living in a multicultural world increases their knowledge in counseling (Stuart, 2004).

The lack of culturally services for racial and ethnic groups can led psychologists and counselors to develop multicultural competencies (Sue, Ivey, & Pedersen, 1996). Research regarding multicultural awareness began with examinations of ethnic minority and cross-cultural populations (Sue et al., 1996). However, recently such investigations have specifically been extended to sexual minorities (Bidell, 2005). Such research has concluded that counselors who exhibited low levels of multicultural awareness also maintained high levels of homophobic attitudes towards sexual minorities (Bidell, 2005; Henke, Carlson, & McGeorg, 2009). Undoubtedly, multicultural competency is needed for a person to be a good counselor ((Bidell, 2005; Henke, Carlson, & McGeorg, 2009). When looking at the demands of a diverse nation, there is a mandate for counselors who are culturally sensitive (Pernell-Arnold, Finley, Sands, Bourjolly, & Stanhope, 2012). The benefits of being a multicultural competent counselor increases the level of awareness and knowledge, which can greatly impact cultural practices from a sociopolitical context (Pernell-Arnold, et al, 2012). Counselors who continue to achieve higher levels of cultural diversity and competencies on a personal and professional level

are better equipped in the counseling environment (Pernell-Arnold, et al., 2012). Counselors' multicultural competencies must go beyond prerequisite levels to meet the needs of clients in our culturally diverse world (Pernell-Arnold, et al., 2012).

Another area of research looked at racial differences in attitudes toward sexual minorities, and some studies argued that Non-Whites tend to have more homophobic attitudes than that of Whites (Yarborough, 2002). A study was conducted to examine racial differences in women's attitudes toward sexual minorities and the findings indicated young Black women's scores were higher than young White women's which indicated young Black women held higher unpleasant and hostile attitudes towards sexual minorities (Vincent, Peterson, & Parrott, 2009). Some studies have demonstrated that Black women have more negative attitudes towards sexual minorities than do White women, yet other studies have shown there is no difference between the two (Keiller, 2010). In a similar study to Vincent et al.'s (2009) to examine racial differences, it was noted that older Black women were hostile and disapproving towards lesbians but were comfortable with other sexual minorities such as gay men and transgendered individuals (Parrott, Peterson, & Bakeman, 2011). To go a step further, findings in the same study also indicated that older White women were comfortable with all sexual minorities whether they were lesbian, gay, bisexual, and/or transgendered (Parrott et al., 2011). In sum, the findings in literature are inconsistent, which indicates that more research is needed on this topic (Parrott et al., 2011).

Research has revealed that there are gender differences in attitudes towards sexual minorities (Herek, 1998). Herek (2002) conducted further research and analyzed

responses from a nationwide survey which indicated that heterosexual men held negative reactions towards sexual minorities whether they were gay or lesbian. Recent work on attitudes toward homosexuals upholds the opinion that heterosexual men and Black women typically have more undesirable attitudes towards sexual minorities (Lemelle & Battle, 2004). For example, heterosexual men have more negative attitudes toward sexual minorities than do heterosexual women (Lemelle & Battle, 2004). However, to date, there is no published research that examined the roles of race and gender in counselors' homophobic attitudes.

Problem Statement

Research suggests that negative homophobic attitudes can be a concern when conducting clinical work with sexual minorities (Morrow & Messinger, 2006). Counselors who are homophobic tend to have negative attitudes towards sexual minorities which can occur in different forms like bias, unfairness, and prejudice (Morrow & Messinger, 2006). Counselors are trained to put aside bias and respect diversity; however, evidence suggests that prejudice towards sexual minorities still exists (Swank & Raiz, 2010). Although sexual minorities tend to bring the same issues as their heterosexual peers into therapy (e.g., mental health issues, substance abuse, relationships, etc.), counselors may need to diminish their heterosexism and/or heterosexual bias towards sexual minorities (Swank & Raiz, 2010). Although there have been some studies that examined homophobic attitudes towards sexual minorities, no studies have investigated the associations of homophobic attitudes with counselors' race, gender, and multicultural competency. I addressed the knowledge gap in this study as well.

Purpose of the Study

The purpose of this quasi-experimental quantitative study examined the associations among counselors' race, gender, multicultural competency, and attitudes towards sexual minorities. The independent (predictor) variables of this study were counselors' gender, race, and multicultural competency. The dependent (criterion) variable was the counselors' attitudes toward sexual minorities. Additionally, in this study I examined whether multicultural competency moderates any associations of gender and race with attitudes towards sexual minorities to examine if the role of multicultural competency differs across groups. Furthermore, scrutinizing the possibility of a relationship between counselors' race, gender, and multicultural competency and attitudes towards sexual minorities may provide more nuanced information regarding whether gender and race have varied associations with attitudes at different levels of multicultural competency. Distinguishing the associations among these variables may enhance the understanding of this bias (Hornsey, Terry, & McKimmie, 2004), which may be important to counselors, the gay and lesbian community, and policy makers. The results of this study may be important to counselors because the findings could help them understand factors that may play a role in their work with people from diverse backgrounds. The findings from this study may be important to the gay and lesbian community so they can obtain the same successful treatment as heterosexual individuals. Lastly, the results of this research could be used by policy makers to develop new laws to help all people from every background.

Research Questions and Hypotheses

I developed the following research questions and hypotheses to guide this study:

Research Question 1: Is counselor gender associated with attitudes toward sexual minorities?

$H_0$1: Counselor gender was not associated with attitudes towards sexual minorities.

$H_1$1: Counselor gender was associated with attitudes toward sexual minorities.

Research Question 2: Is counselor race associated with attitudes toward sexual minorities?

$H_0$2: Counselor race was not associated with attitudes towards sexual minorities.

$H_1$2: Counselor race was associated with attitudes towards sexual minorities.

Research Question 3: Does counselor multicultural competency moderate the association of counselor race or gender with attitudes towards sexual minorities?

$H_0$3: Counselor multicultural competency did not moderate the association of race or gender with attitudes towards sexual minorities.

$H_1$3: Counselor multicultural competency did moderate the association of race or gender with attitudes towards sexual minorities.

Theoretical Foundation

Multicultural competency, developed by Sue, Ivey, & Pedersen, (1996) were the theoretical foundation I used for this study. This theory emphasizes how counselor attitudes, awareness, expertise, and proficiency affects the counseling environment when counselors are not equipped to work with people of different ethnic/cultural groups or people who are gay or lesbian (Sue et al., 1996). The basis of this multicultural theory is to improve the counselors' skills concerning their unintentional biases and negative attitudes toward diverse populations (Sue et al., 1996). This theory applied to this study because the level of multicultural competency when working with diverse populations, including the gay and lesbian population, indicates that counselor attitudes, like homophobia, can negatively affect the counseling environment.

Multicultural competency incorporates an individual's racial, ethnic, sexual orientation, religiousness, and upbringing into treatment (Sue et al., 1996). In other words, multicultural counseling takes into consideration cultural factors and the effect that they can have on counseling (Sue et al., 1996). In most cases, counselors should acknowledge that each client is unique and all personal differences should be recognized and respected (Sue et al., 1996). However, current theories of counseling and psychotherapy unsatisfactorily describe, explain, foretell, and address cultural diversity (Sue et al., 1996). It is important that counselors acknowledge their own values as well as the world view of the culturally different client, thereby allowing them to apply appropriate intervention strategies and techniques to all clients regardless of their race,

ethnicity, and/or sexual orientation (Sue et al., 1996). I discussed multicultural competency in greater detail in Chapter 2.

Nature of the Study

I conducted this quantitative study using survey methodology. I employed three independent (predictor) variables in this study (the counselors' gender, race, and multicultural competency) and one dependent (criterion) variable (the counselors' attitudes regarding sexual minorities). My goal was to examine whether the independent (predictor) variables were associated with the dependent (criterion) variable. Multicultural competency was examined both as an independent linear predictor as well as a moderator of the associations between race, gender, and attitudes toward sexual minorities to determine if multicultural competency is differentially associated with attitudes toward sexual minorities across different counselors based on their race or gender. For example, women's attitudes toward sexual minorities may not be associated with their level of multicultural competency, while men's attitudes may be significantly associated with their multicultural competency. By examining multicultural competency as a moderator, the results of this study can further demonstrate the conditions under which the predictors are connected to the criterion variable (see Hayes & Matthes, 2009).

To describe the sample of participants, I developed a demographic questionnaire form and used it to gather personal information regarding their age, race, gender, years of experience working in the field, degree acquired, average number of patients seen per month, and the average number of patients who identified themselves as a sexual minority. The counselor's gender consisted of six possible levels: woman, man,

transman, transwoman, genderqueer/gender nonconforming, or gender not listed. This questionnaire was also used to help categorize the sample in this study. For demographic purposes, the counselor's race consisted of seven possible options: Black/African American, Native American or Alaskan, Hawaiian or Pacific Islander, White/Caucasian, Hispanic or Latino/a, Asian or Asian American, or race/ethnicity not listed. I placed importance on obtaining data that could incorporate information for the testing of my hypotheses regarding the relationship between the variables of interest.

I used the Multicultural Counseling Knowledge and Awareness Scale to measure multicultural competency in this study (see Ponterotto & Potere, 2003). The second instrument I used in this study was The Attitude Toward Lesbians and Gay Men Scale (see Herek, 1998). This instrument was used to measure counselor attitudes. There are two subscales within this instrument, and therefore, the attitudes towards gay and lesbian people were measured separately. There were 20 questions total, 10 questions based on attitudes towards gay men and 10 questions that addressed attitudes towards lesbians.

I collected data from 40 participants through an online survey using Survey Monkey. Solicitation and information to participate in this study was posted on the American Counseling Association (ACA) website for counselors, the Walden University Participants Pool, and to licensed counselors registered under Exact Data. Prior to data collection, I received approval from the Walden University Instructional Review Board (IRB).

Definitions

Attitude: An acceptable or unacceptable assessment of a person or thing (Herek, 2004). Attitudes are also defined as either optimistic and/or negative beliefs about a person, place, thing or event (Herek, 2004).

Bias: No approval or not in favor of thing, person, or group or when a person shows prejudice against somebody or something (Herek, 2004).

Bisexual: A romantic attraction toward both men and women regardless of the individual's biological sex or gender (American Psychological Association, 2013).

Diversity: The uniqueness and individuality amongst human beings (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2009).

Gay: A "male being sexually attracted to another male" (Herek, 2004, p. 15).

Gender: Biological characteristics in the state of being born male or female based on body makeup (Herek, 2004). Gender is also defined as attitudes, feelings, and actions that society links with an individual's biological sex (American Psychological Association, 2013). Gender can also be defined as behavior that is harmonious with cultural beliefs, and when individuals' behaviors are not viewed as harmonious with cultural beliefs, they are termed gender nonconforming (American Psychological Association, 2013).

Heterosexism: Discrimination against gay men and lesbians who challenge conventional gender roles and prejudice against any other sexual orientation other than heterosexuality (Herek, 2004).

Heterosexuality: The sexual desire or sexual attraction toward a person of the opposite sex (Herek, 2004). For instance, if you are male you are sexually attracted to women, and if you are female you are sexually attracted to men (Herek, 2004).

Homophobia: A hostile reaction to lesbians, gay, bisexual, and transgender people (Herek, 2004).

Homophobic attitudes: The mindset of heterosexual people who believe they are superior to gay and lesbian individuals (Herek, 2004).

Lesbian: A female being sexually attracted to another female (Marlin, 2004).

Licensure: The process by which a state agency and/or government entity gives permission to indicate a person has met the necessary requirements or received a degree to indicate competency in study (CACREP, 2009).

Multicultural competency: A set of corresponding behaviors and guidelines in which systems, agencies, and health care professionals can work effective to serve people due to cultural differences (CACREP, 2009).

Multicultural counseling: A type of psychotherapy that is sensitive to cultural and racial diversities, including sexual orientation, spirituality, disabilities, and societal, economics (CACREP, 2009).

Race: A system used to categorize humans in large groups by cultural, ethnic, genetic, historical, or social affiliation (Herek, 2004).

Sexual minority: A group of people whose sexual identity is not the same as most society. This term is mainly used when one is referring to individuals are lesbian, gay, or bisexual (American Psychological Association, 2013).

Sexual orientation: The object of desire or love for a subject or a persons' sexual desire toward people of the opposite sex, same sex, or both sexes (American Psychological Association, 2013).

Transgender: A person's behavior which involves tendencies that are different from an individual's gender identity and the assigned sex of the individual (American Psychological Association, 2013).

Assumptions

I assumed that participants replied to all the survey questions truthfully and honestly. In the survey instructions, I reminded participants that their responses were anonymous to facilitate truthful responding. These assumptions were necessary in the context of this study because in quantitative studies it is important that data were not biased or influenced by researcher demand when using correct and appropriate measures based on constructs of this study (see Babbie, 2007). Before conducting the analyses, all statistical assumptions were tested and, if necessary, remedied appropriately prior to conducting final analyses.

Scope and Delimitations

The delimitations of the study were based upon the geographic location and the age, sex, and size of the participant population. For instance, this study was limited to counselors licensed by the ACA. For this study, participants were exclusively heterosexual because previous research has indicated that heterosexual individuals are more likely to be biased and prejudiced toward sexual minorities than homosexual individuals (Herek, 2004). Participants must have had at least 3 years of experience

working in the counseling field and must have had at least a Bachelor's degree in the field of social work, psychology, or a related field. Participants had to be between 18 and 70 years of age at the time of the study.

Limitations

As with all studies, this study also had limitations. I used a voluntary sample in this study, due to the fact the subjects were taken from a specific group of counselors licensed by the ACA. Voluntary sampling is a nonprobability style in which individuals are used in a sample because they are readily available (Battaglia, 2008). Therefore, this allows the researcher to achieve the sample size in a relatively short period of time (Battaglia, 2008). My ability to detect differences in responses among racial subgroups of non-White participants could have been an issue due to the small sample size needed to complete this study. Another limitation may have been that participants had the ability to not answer all the questions or might not have been completely honest when answering the questions. Participants were made aware that the data were being collected anonymously to encourage them to answer all questions and to be as honest as possible.

Another area of concern was self-selection bias, a situation where people select themselves into a group that can result in a biased sample (see Jacobs, Hartog, & Vijverberg, 2009). In some cases, the uniqueness or distinctiveness of individuals can create abnormal or undesirable results (Jacobs et al., 2009). The recruitment materials I made available to participants through the website of ACA was worded in a way that minimized self-selection bias.

In this study, I used a quantitative, correlational design. With this technique, the researcher has no control over the exogenous variable (Lammers & Badia 2005), and it is important that groups are similar on all variables and that the exogenous variables are clearly defined to prevent error (Lammers & Badia, 2005). Generalizability is a major concern in research and as with any study, the concept of generalizability must be considered (Compeau, Marcolin, Kelly, & Higgins, 2012). The study results may not generalize to other counselor populations, such as those who are not members of the ACA.

Significance of the Study

The goal of this study was to provide a contribution that would advance counseling practice and/or policies. In 2005, the ACA adopted and established new competencies to help counselors work meritoriously with gay and lesbian individuals (CACREP, 2009). As guidelines are established to better prepare counselors to work with lesbian and gay clients, counselor-training programs and curriculum are also created to improve competency levels to work with this population (CACREP, 2009). The results of this study may provide information regarding which counselor variables are associated with a greater likelihood of holding homophobic attitudes, thereby suggesting variables upon which to target increased training around multicultural issues such as sexual orientation (see CACREP, 2009). I hope that such training would ultimately improve counselors' abilities to provide effective and unbiased counseling to sexual minority clients. Additionally, the knowledge gained from this study may assist policy makers and help them develop and introduce new laws to protect the rights of sexual minorities.

Summary

In this introductory chapter, I provided the background and purpose of this study. In the problem statement section, I explained the relevance of this study and presented the three research questions. Key definitions were provided, the assumptions and limitations of the study were described, and the significance of this study was introduced. In Chapter 2, I will present the existing research regarding the relationships among counselor gender, race, and multicultural competency as they relate to the attitudes of counselors when counseling sexual minority clients.

Chapter 2: Literature Review

Introduction

The purpose of this study was to investigate the relationships among counselors' gender, race, and multicultural competency as they relate to their attitudes about sexual minorities. Current literature has indicated that counselors' homophobic attitudes can negatively affect the therapeutic relationship when the client is gay or lesbian (DePaul, Walsh, & Dam, 2009; Kissinger, Lee, Twitty, & Kisner, 2009; Swark & Raiz, 2007, 2010). Homophobic attitudes are formed and composed through a learning process in which an individual labels others, and this perception can lead to negative attitudes and prejudice (Swark & Raiz, 2007). Homophobic attitudes play a major role in the treatment and actions displayed against sexual minorities (Bryant & Vidal-Ortiz, 2008). Counselor biases and preconceptions need to be addressed to prevent harmful aftereffects that sexual minorities may be subjected to endure in a homophobic counseling environment (Bryant & Vidal-Ortiz, 2008). There has been some research conducted that has investigated the role of counselors' multicultural counseling competency when counseling sexual minorities (Bryant & Vidal-Ortiz, 2008); however, there has been little to no research examining counselors' attitudes based on their race or gender when counseling sexual minorities (Goodman & Moradi, 2008).

In this chapter, I will detail the major results of the literature review that provided motivation for the study. The literature search strategy of this study will be introduced, followed by a description of the theoretical foundation, and then a discussion of studies related to the constructs of this study (e.g., attitudes regarding sexual minorities and their

associations with gender, race, and multicultural competency). In the summary and conclusions section that ends the chapter, I will describe the gap in the literature and explain why this study was needed.

Strategies for Searching the Literature

I used several search strategies to locate literature to review for this chapter. The databases I used in searching the literature included PsycINFO, PsycArticles, Academic Search Premier, and SAGE Research Methods Online. The keywords used during this search included *attitudes*, *bias*, *homosexual*, *heterosexual*, *heterosexism*, *homophobia*, *gay*, *lesbians*, *diversity*, *multicultural competency*, and *race*. The EBSCOhost database allowed me to access peer-reviewed scholarly articles and dissertations with similar research topics published by Walden University students. After obtaining the results from the EBSCOhost system through Walden University, articles were examined for their content and only those relevant to the study topic were retained. Additionally, I examined the references cited in the original articles to determine if they were appropriate for inclusion in this study. Literature was chosen from approximately 350 articles examined and, of those, 145 articles were relevant based on comparison to the research topic, research questions, and purpose of this study.

Theoretical Foundation

The foundation of this study was multicultural competency, which was developed by Sue et al. (1996). The underlying assumptions of this theory suggest that counselors meet and work with clients who are different from themselves due to their race, culture, and/or ethnicity (Sue et al., 1996). Negative attitudes about others may surface in

counseling sessions when counselors are not adequately prepared to engage in multicultural interactions (Sue et al., 1996). Multicultural competency is designed to assist counselors with their repertoire of skills, which may help counselors be aware of intentional and negative attitudes toward gay and lesbian people (Sue et al., 1996).

At one point or another in a counselor's career, he or she meet and work with people from diverse populations (Rawson, Whitehead, & Lutheran, 1999). Thus, multicultural counseling competency is a necessary skill to be successful in the counseling environment (Arredondo & McDavis, 1992; Rawson et al., 1999). Multicultural counseling competencies were described, amended, modified, and operationalized with objectives that multi-culturally trained counselors are better equipped to provide effective counseling to ethnically diverse clients (Arredondo & McDavis, 1992; Arredondo et al., 1996; Pedersen et al., 2005). Multicultural counseling competency is a technique that is suitable when working with people from diverse populations and/or sexual minorities (Sue & Sue, 2013).

In considering how multicultural competency is applicable to this study, it is important to understand the meaning of the word *culture* (Tomlinson-Clark & Clark, 2010). Culture is defined as the standards and customs that influence how people of certain group believe, intermingle, respond, and make decisions about the world in which they live (Tomlinson-Clark & Clark, 2010). Improving multicultural competency entails examining biases and prejudices to improve skills for working with diverse clients (Arredondo, Tovar-Blank, & Parham, 2008). Simply stated, multicultural competency is defined as knowledge-based skills that are essential and vital to provide effective clinical

care to clients from an ethnic or racial group (Arredondo et al, 2008). Multicultural competency is geared towards preventing treatment errors and enhancing treatment for individuals from diverse populations such as sexual minorities (Tomlinson-Clark & Clark, 2010). To be multicultural competent, counselors must be aware of their own cultural worldview and conscious of their attitude towards cultural differences (Priester et al., 2008; Sue & Sue, 2013).

Multicultural competency involves three factors that are essential when counseling sexual minorities and diverse populations: consciousness, knowledge, and expertise (Arredondo & McDavis, 1992; Arredondo et al., 1996; Bidell, 2005; Priester et al., 2008). Within a multicultural competency context, consciousness refers to knowing yourself cognitively and psychologically in the context of diversity (Malott, 2010). Counselors who understand diversity are more likely to consider different worldviews and take part in reflective thinking when making decisions about situations that may differ from their own (Malott, 2010). Counselor knowledge is the understanding that there are different ways of living life and recognizing differences amongst clients and their belief systems (Pernell-Arnold, Finley, Sands, Bourjolly, & Stanhope, 2012). Knowledge becomes apparent when counselors provide extraordinary service, valuable communication, and respect of another person's diverse background (Pernell-Arnold et al., 2012). Expertise in the field is critical work when working with sexual minorities and requires a counselor to be multicultural competent (Betancourt & Green, 2010; Lie, Shapio, Cohn, & Naim, 2009; Roberts, Sanders, Sanders, & Wass, 2008). With a high level of expertise, a counselor can consider themselves and others in insightful, reflective

ways that acknowledge diversity (Betancourt & Green, 2010). Consciousness, knowledge, and expertise bring an understanding to working with diverse clients that allows counselors to become more competent and effective professionals (Betancourt & Green, 2010).

To work with sexual minorities and people from different backgrounds, counselors need to have the necessary skills and training to be effective (Rawson et al., 1999). Multicultural counseling competency requires a counselor to have the erudition to understand that age, gender, race, ethnicity, national ancestry, religious belief, sexual orientation, disability, language, and socioeconomic status can influence clients' lives in the counseling environment (Sue et al., 1996; Sue & Sue, 2013). The components of this theory are applicable when working with sexual minorities because multicultural counseling competency results in an ability to understand, communicate with, and effectively interact with people across diverse cultures (Sue et al., 1996). In this study, I developed and focused on three research questions that were built on this existing theory.

Multicultural competency has been applied in other research studies as well. Researchers have suggested that counselors' personal characteristics, such as race, gender, and socioeconomic status, are associated with their level of multicultural competency (Chao, Wei, Good, & Flores, 2011; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998). For example, one study indicated that Black and Latino counselors had a higher level of multicultural counseling competency compared to White counselors (Constantine & Gushue, 2003). Studies have also indicated that receiving training in multicultural competency can reduce negative attitudes when working minority or ethnic

groups (Chao, Wei, Good, & Flores, 2011). For example, a study investigating graduate students' attitudes toward sexual minorities indicated that students' negative attitudes and prejudice decreased and cultural knowledge and skills increased, after taking a multicultural course (Castillo, Brossart, Reyes, Conoley, & Phoummarath, 2007). A study conducted by Ginger, Argus-Calvo, and Tafoya (2010), indicated similar results showing that negative attitudes towards sexual minorities were lowered when multicultural training was received.

Counselor Attitudes

Attitudes can be expressed and defined in many ways. Attitudes are more than a thought pattern or a mood a person may be in, but instead are the actual behavior or the mindset of an individual (Eagly & Chaiken, 1998). Attitudes, in general, contribute to negative bias against sexual minorities when thoughts are developed based upon a learning process (Van Overwalle & Sieber, 2005). Based on previous experience in a person's life, attitudes are formed based on their encounters with similar situations (Van Overwalle & Sieber, 2005).

Homophobic attitudes, which comprise one aspect of homophobia, are critical to consider when examining behaviors towards sexual minorities. According to Berkman and Zinberg (1997), homophobia is defined as an undesirable way of thinking about homosexuality. Homophobia, defined by Herek (2004), is the hostile reaction towards sexual minorities through an individual's attitudes and behaviors. Further, homophobia has been defined as fear, anger, disgust, hatred, and awkwardness toward sexual minorities (Brownlee et al., 2005).

Heterosexism also plays a critical role in attitudes towards sexual minorities (Herek, 2007). Heterosexism is founded on the idea that heterosexual relationships are the only standard or appropriate way of conveying a person's sexuality (Herek, 2007). Consequently, heterosexism is a societal belief that degrades any form of relationship other than a heterosexual relationship (Herek, 2007). The term heterosexism is utilized to understand the stigma associated with homosexuality because heterosexism is a form of prejudice that influentially affects other people (Fish, 2008). Heterosexism refers to a worldview where heterosexuality is the standard of living for all people, and human beings who do not fit this norm of being heterosexual are often thought of as different and immoral (Fish, 2008). Heterosexism can strengthen existing biases against sexual minorities and produce unfair behaviors towards sexual minorities (Brown, Smalling, Groza, & Ryan, 2009). The expression of heterosexism is connected to a person's age, topographical location, and their sex (Brownlee et al., 2005). Older men are more susceptible to exhibit heterosexist attitudes than are younger men, and heterosexist attitudes tend to be stronger in rural areas (Brownlee et al., 2005).

Heterosexist and homophobic attitudes can lead to negative biases that can cause inadequate therapy towards individuals based on their race, gender, ethnic background, and/or their sexual orientation (Kassam, Wasiams, & Patten, 2012). Sexual minorities are subject to negative biases in health care and may have difficulty obtaining support from social workers and other professionals (Foreman & Quinlan, 2008). According to Forshaw and Pilgerstorfer (2008), biases can be either direct or indirect and can produce inadequate treatment due to a negative impression towards an individual or group based

on individual characteristics. Depriving a person or a group of people of professional and effective therapy solely based on the individual characteristics of the person is bias, and sometimes these biases occur in the counseling environment (Forshaw & Pilgerstorfer, 2008).

As counselors, it is crucial to recognize that persons who are homosexual must deal with society's adverse reactions to them as well as other possible reasons they make be seeking treatment (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000). Lesbian and gay clients undergo psychotherapy at a higher rate than do heterosexual women and men (Martinez, Vázquez, Falomir-Pichastor, & Juan, 2015). Living in a heterosexist society plays a critical part of additional challenges for individuals who are not heterosexual (Martinez et al., 2015). Homophobic attitudes that may facilitate mistreatment towards sexual minorities are still prevalent today (Corey, Schneider-Corey, & Callahan, 2011). Some counselors find it difficult to separate their personal views of sexuality from their professional approach towards sexual minorities (Corey et al., 2009). Moreover, training shortfalls regarding working with sexual minorities may result in some counselors being inadequately prepared to counsel sexual minorities (Corey et al, 2009). When a counselor is inadequately prepared to counsel sexual minorities, the likelihood of heterocentrism and homophobia may evince therapeutic biases towards sexual minorities during treatment (Mustanski, 2015). Even though sexual minorities tend to utilize psychotherapy more than the general population, in some cases counselors tend to demonstrate biases due to heterocentrism and homophobia (Mustnski, 2015).

Bias towards sexual minorities in the counseling environment may present itself in several ways. As described by Pachankis and Gonsiorek (2013), inappropriate treatment of sexual minorities can occur when the counselor assumes the client is heterosexual. Once the sexual orientation is revealed, the counselor may attempt to focus on the sexual orientation instead of the issues at hand being presented by the client (Pachankis & Gonsiorek, 2013). Additional ill-treatment can transpire when the counselor is oblivious to the differences amongst sexual minorities (Johnson, Corliss, Molnar, & Azrael 2009). In turn, this can cause anxiety and unnecessary stress to the minority client seeking treatment (Johnson et al., 2009). Moreover, in a survey conducted with a diverse sample of psychologists, results indicated a vast amount of biased treatment towards sexuality minorities stemmed from counselors attempting to try to change the client sexual orientation (Anhalt, Morris, Scotti, & Cohen, 2003). Refuting such biases is essential to establishing ethical practices when counseling sexual minorities (Pachankis & Gonsiorek, 2013).

From a professional standpoint, counselors should be equipped to work with all groups of people (Anhalt et al., 2003). In order to become proficient as a counselor and work with a diverse group of people, training and education must be done regularly (Anhalt et al., 2003). If a counselor has any level of homophobia, it may inhibit positive and effective outcomes when counseling sexual minorities (Anhalt et al., 2003). Research done by Minami (2008), found that homophobia can damage the therapeutic relationship when counseling sexual minorities. It is not unusual for sexual minority clients to encounter unaccommodating psychotherapy practices such as, heterosexual bias,

ignorance of concerns that are exclusive to sexual minorities and belittling of sexual orientation (Israel, Gorcheva, Burns, & Walther, 2008). Research suggests that mental health professionals do not always embrace best practices when working with sexual minorities (Israel et al., 2008). More than one third of the sexual minority clients in this research described their counselor as disconnected, aloof, unfriendly, isolated, and disrespectful (Israel et al., 2008; Johnson, Corliss, Molnar, & Azrael, 2009).

The relationship between counselor and client is significant and influences the outcome of treatment (Gelso, 2014). Research done by Kelley (2015), examined the relationship between lesbian and gay clients have with their counselor. Results indicated that 25% of the clients reported that their counselor lacked knowledge about lesbian and gay issues. It was also noted that 21% of the clients indicated that their counselor was nonchalant and indifferent and regarded their sexual orientation as their primary issue (Kelly, 2015. One-third of clients in this study indicated that they preferred a homosexual or gay-friendly counselor instead of a heterosexual counselor (Kelley, 2015). Moreover, other studies indicated that some sexual minorities are reluctant to even seek treatment due to fear of discrimination and bias (Shelton & Delgado-Ramero, 2011). To alleviate the above concerns, health care professionals need to allow sexual minorities to feel safe and welcome to the counseling environment (Sue & Sue, 2013). A counselor with more cultural competency training is more likely to be able to provide effective counseling to the culturally diverse client (Sue & Sue, 2013).

Differences as It Relates to Gender

Over the last few decades, research has been done to examine negative attitudes toward homosexuality based on gender (Cuddy & Fiske, 2004). Researchers have found differences between the attitudes of heterosexual men and heterosexual women towards homosexuality (Cuddy & Fiske, 2004). A study done a few years after Cuddy and Fiske (2004), found that heterosexual men hold a more negative view of homosexuality than do heterosexual women (Anderson, 2009). Heterosexual women tend to have a more favorable attitude toward gay people, and heterosexual men were more likely to condemn gay men but were a bit more lenient towards lesbians (Anderson, 2009). On the contrary, based on the study done by Anderson (2009), researchers LeFave, Helm and Gomez (2014), found that men tend to hold more negative attitudes towards homosexuality whether they are gay or lesbian. Research also showed heterosexual men were more comfortable with heterosexual situations than with homosexual situations (LeFave et al., 2014). Heterosexual women overall were more comfortable with heterosexual situations as well, but were more likely to tolerate gay men than lesbians (LeFave et al., 2014). In sum, gender does play an important role in attitudes towards homosexuality, and heterosexual men in general tend to hold more negative attitudes towards homosexuality more so towards gay men than lesbians (Daboin, Peterson, & Parrott, 2015).

Differences as It Relates to Race

Race plays a critical role when investigating attitudes toward homosexuality (Finlay & Walther, 2003; Jenkins et al., 2009; McVeigh & Diaz, 2009). In general, Whites tend to be more tolerant of homosexuality than do Black and other Non-White

individuals (Bonilla & Porter, 1990; Brown & Henriquez, 2008; Lewis, 2003; Schulte, 2002). For example, a study done by Lewis (2003), found that Blacks hold more negative attitudes toward homosexuals than Whites. According to Schulte and Battle (2004), compared to Blacks, Whites expressed less negativity toward both lesbians and gay men. In a study that examined both racial and gender differences toward homosexuality, Vincent et al., (2009), found that Black women tend to hold more undesirable attitudes towards homosexuality than do White women. This study also indicated that Black men were less accepting of homosexuals than White men (Vincent et al., 2009). While there is, some research comparing racial differences in attitudes toward homosexuality between Blacks and Whites, there is still much to be known about attitudes of other Non-Whites (Lewis & Gossett, 2008). Only a handful of studies have compared the attitudes of Hispanics toward homosexuality and the results of each study indicated that the attitudes of Hispanics was more favorable than Blacks but less favorable than Whites (Lewis & Gossett, 2008). In sum, research consistently indicates that Whites are more likely to be accepting of homosexuality than that of Non-Whites races such as: Black/African American, Native American or Alaskan Native, Hawaiian or Pacific Islander, Hispanic or Latino/a, or Asian or Asian American (Lewis & Gossett, 2008).

Multicultural Competency

Multicultural competency has been emphasized in theory, research, training, and practice (Sodowsky, Kuo-Jackonson, Richardson, & Corey, 1998). Many programs have incorporated multicultural competency as accreditation standards for upcoming counselors (Sodowsky et al., 1998). For a counselor to have a comprehensive approach to

counseling, one must understand diversity to counsel individuals from various backgrounds (Sodowsky et al., 1998; Stadler, et al., 2006). One study indicated that multicultural competency is a core component and is used as a blueprint and theoretical theory for counselors and mental health providers when working with people from different cultures (Odegard & Vereen, 2010; Sue & Sue 2013). A counselor being able to assimilate a client's culture in the counseling environment is more likely to provide effective treatment delivery to clients from various backgrounds (Sodowsky et al., 1998; Smith et al., 2006).

The higher level of knowledge a counselor has working with diverse clients may allow them to be more equipped with this population (Odegard & Vereen, 2010). In turn, researchers (Smith et al., 2000; Sue & Sue, 2013) agreed that multicultural competency was referred to as the cornerstone of ethical practice and must be learned to provide accurate service to people with various backgrounds. Multicultural competency requires more than reading a book, having a diverse background, or exposure to people from other cultures (Pope-Davis, Reynolds, Dings & Nielson, 1995; Sodowsky et al., 1998). Specific and thorough training in this area is needed to develop multicultural competent counseling skills (Murray, Poke & Rowell, 2010). Lastly, a culturally competent counselor who has acquired multicultural competency counseling has been known to effectively work with diverse groups (Murray, et al., 2010).

In times past, multicultural competency was referred to as working with ethnic and racial minorities; however, now the concept includes culturally diverse populations (Smith, Constantine, Dunn, Dinehart & Montoya, 2006; Ratts & Wood, 2011).

Multicultural competency provides a foundation for counselors to focus on the culture of the client in the counseling setting to provide better service delivery to this population (Smith, Constantine, Dunn, Dinehart & Montoya, 2006; Ratts & Wood, 2011). In turn, multicultural competency is effectively delivered when counselors can objectively interpret differences amongst people in the counseling environment (Consoli, Kim, & Meyer, 2008). Within the same study, benefits of multicultural competency in counseling indicated counselors working who lack education in multiculturalism also lacked the knowledge and skills needed to work with sexual minorities (Consoli et al., 2008). Results also indicated treatment towards sexual minorities can be impacted in the counseling environment due to poor multicultural competency (Consoli et al., 2008). In a similar study done by Cannon (2008), results indicated that professional associations have acknowledged that when multicultural competency is not incorporated in counselors' training, sexual minorities tend to be treated unfairly in diagnosis and interventions.

There is a critical need for counselors to understand diversity and be culturally trained to counsel individuals from diverse populations (Satcher & Schumacker, 2009). Counselors must be able to accept clients as individuals or an as a group, to fully understand differences amongst people on all levels (Satcher & Schumacker, 2009). Therefore, in addition to concentrating on the client, the position of the counselor is to place emphasis on the client's systems and when possible, incorporate systems to bring about change in therapy (Satcher & Schumacker, 2009). If health care professionals and practitioners are not willing to acknowledge their biases and attitudes associated to

multicultural incompetency, then their adeptness to work in a diverse working setting was be hindered (Ponterotto, Fingerhut & McGuinness, 2012). Additionally, if health care professionals and practitioners work on their personal biases but are unwilling to address their professional biases in relation to multiculturalism, the work setting was continuing to be culturally encapsulated (Ponterotto et al., 2012). Thus, being multicultural competent is instrumental in counseling and if counselors continue to be invested in developing this competency, multiculturalism was continuing to help diverse clients to receive effective counseling (Ponterotto et al., 2012). In sum, multicultural competency is essential when providing service to the culturally diverse client, and the lack of multicultural competency in the counseling environment may affect decision making and limit the counselor's ability to provide appropriate treatment to sexual minorities (Sue & Sue, 2013).

Summary

Chapter 2 described the foundations of this study and discussed literature examining attitudes towards sexual minorities. This chapter also presented demographic predictors, such as race and gender of counselor's attitudes towards sexual minorities. The gap in the literature was investigated by what studies have or have not be conducted on this topic of interest. Chapter 3 focused on the methodology proposed to conduct this study. Many components were be introduced such as: the research design and rationale for the study, the population, sampling and sampling procedures, instrumentation and operationalization of constructs and data analysis plan, reliability and validity of selected instruments and the confidentiality of results were explained. This section introduced the

dependent and independent variables (predictor) used for analysis and indicated how each variable was measured. Lastly, a description of the data analysis were clearly defined and outlined in this chapter.

Chapter 3: Methodology

Introduction

The purpose of this study investigated the relationships among counselors' attitude, gender, race, and multicultural awareness as they relate to counseling sexual minority clients. In this chapter, I focused on the methodology that was employed for this study. This chapter contained information on the research design and rationale, the sample population and survey procedures, instrumentation and operationalization of constructs, instruments used in the study, data collection, analyses, and threats to validity, and ethical procedures in order to protect participants in this study.

Research Design and Rationale

For this purpose of this study, I used three predictors (independent variables): counselors' gender, counselors' race, and counselors' multicultural competency. One criterion (dependent variable) was used: the counselors' attitudes towards sexual minorities. Attitudes toward gay men and lesbians was measured separately because the instrument The Attitudes Toward Lesbians and Gay Men (ATLG) has two subscales.

My rationale for using a quantitative study approach was that this method is best used when attempting to find the association among different variables (Cohan, Manion, & Morrison, 2008). The quantitative approach pursues facts and is utilized when scholars want to procure arithmetical relationships (Cohan et al., 2008). According to Gall, Gall, and Borg (2003), quantitative research uses scientific methods in which variables are measured numerically. An ex post facto design is a nonexperimental study method in which preexisting groups are compared on a dependent variable (Lammers & Badia,

2005). I used an ex post facto design in this study because I examined two or more groups of individuals with similar backgrounds who had been exposed to different conditions because of their natural histories (see Lammers & Badia, 2005).

In this study, I used an assessment tool composed of closed structured or open-ended questions in order to gather data from participants thought to be representative of the same population (see Gall et al., 2003). I used surveys in order to conduct this study which I found to be effective. Using surveys is one of the leading forms of data collection for the effective collection of data over broad populations (Gall et al., 2003). Regardless of how the surveys are administrated, whether in person, by telephone, the mail or over the Internet, surveys are known to obtain useful and appropriate results (Gall et al., 2003). With that noted, online surveys have been found to attain greater response rates than that of the traditional mail out surveys because of their convenience for participants (Creswell, 2009). Surveys are also cost-effective for collecting a large amount of data in a short period of time (Babbie, 2007). None of these procedures were carried out or data collected until I received the approval by the IRB from Walden University.

Population

Using a voluntary sample, I drew participants for this study from the population of licensed counselors in the United States who are members of the ACA, the Walden University Participant Pool, and purchased e-mail lists from Exact Data of professional counselors. From July 2, 2016 until October 14, 2016, an invitation to participate in my

study was posted on the ACA website, the Walden University Participant Pool, and in e-mails sent to professional counselors from Exact Data database.

Sampling and Sampling Procedures

I am a member of the ACA and was given permission to use the website to solicit participants for this study. The survey I used in this study was hosted using Survey Monkey. There was a link associated with the advertisement on the ACA website. It was clear in the solicitation that heterosexual licensed counselor who worked as a social worker, psychologist, career counselor, guidance counselor, school counselor, mental health counselor, or addiction/substance abuse counselor or other closely related field were the guidelines to participate. Other inclusion criteria included licensed providers were between the ages of 18–70 with at least 3 years of experience in the counseling field. Along with licensed counselors registered under the ACA organization, participants were from the Walden University Participant Pool and licensed counselors registered with Exact Data. All data were collected and scored using Survey Monkey.

I conducted power analyses to compute a priori sample size estimates using G*Power 3.1 (Faul, Erdfelder, & Buncher, 2009). Hierarchical linear multiple regression was used to test hypotheses. For hierarchical linear multiple regression, I used an effect size of 0.15 with an error probability of 0.05, power of 0.80, and three predictors, so the estimated total sample size was 77 participants. However, after having much difficulty collecting data, I closed the survey after 40 participants took my survey with the direction my committee and no other data was collected. A demographic form was used to ensure participants met the criteria to participate in this study. After the screening process,

participants who met the requirements were given access to the survey. There were no incentives offered to participate in this study.

Instrumentation and Operationalization of Constructs

In this study, I used three instruments to measure variables. The first instrument was a demographic questionnaire that I developed. The second instrument was the ATLG, developed by Herek (1998). The ATLG has two subscales that were broken down into two sections and measured attitudes towards gay men and lesbians separately (Herek, 1998). The third instrument was the Multicultural Counseling Knowledge and Awareness Scale (MCKAS), developed by Ponterotto & Potere (2003). Both the ATLG and the MCKAS instruments were completely acceptable and harmonious with earlier studies in which the scales were used.

Demographic Questionnaire

I developed a demographic form to gather information from the participants regarding their age, race, years of experience, field of study, educational level, average number of patients seen per month, and average number of patients who have identified themselves as a sexual minority. In this questionnaire, I described the sample of participants of this study. Age was measured when participants selected their age category, and if participants were over the age of 70, they were asked to write their age. Race was measured using seven categories: 1 = *Black/African American,* 2 = *Native American or Alaskan native,* 3 = *Hawaiian or Pacific Islander*, 4 = *White/Caucasian,* 5 = *Hispanic or Latino/a,* 6 = *Asian or Asian American, or* 7 = *race/ethnicity not listed*. Participants could check all that applied. Gender was measured using six response

options: 1 = *Woman,* 2 = *Man,* 3 = *Transman,* 4 = *Transwoman,* 5 = *Genderqueer/gender nonconforming, or* 6 = *Gender not listed* (with fill-in-the-blank option). I measure their educational level by asking participants to state their highest degree: 1 = *Bachelor Degree,* 2 = *Master's Degree, or* 3 = *Doctorate Degree*. The field of study was measured using eight categories: 1 = *social worker,* 2 = *psychologist,* 3 = *career counselor,* 4 = *guidance counselor,* 5 = *school counselor,* 6 = *mental health counselor,* 7 = *addiction/substance counselor, or* 8 = *other counselor*. The average number of patients seen per month was measured using a scale of 0–20 or more patients. Lastly, the average number of patients who have identified themselves as a sexual minority seen per month was measured using a scale from 0–20. If this number was not known, participants were asked to select "I don't know" as a response. The reason for collecting this data was to define the population of participants who took the survey. The complete demographic questionnaire form can be found in Appendix J.

The Attitudes toward Lesbian and Gay Men Scale

I used the ATLG Scale to measure the attitudes of counselors' regarding sexual minorities. In 1998, the ATLG was revised and now only consists of 20 items instead of 64 items (Herek, 1998). This scale has been proven to be a sufficient tool to measure predictors of negative and sexual bias toward sexual minorities (Stoverver & Morera, 2007). Since the development of this scale (Herek, 1998), it has been considered one of the most widely used scales of attitude in general measuring attitudes towards lesbians and gay men (Stoverver & Morera, 2007). Within this instrument there are 10 questions/items that refer to gay men (ATG subscale) and there are 10 questions/items

that refer to lesbians (ATL subscale; (Herek, 1998). Participants indicated their level of agreement or disagreement to each question/item. This instrument has a 5- point Likert-type scale that incorporates answers from *strongly disagree to strongly agree* (1 = *strongly disagree,* 2 = *disagree somewhat,* 3 = *neither agree nor disagree,* 4 = *agree somewhat,* 5 = *strongly agree*). The higher the score, the more negative the attitudes are towards sexual minorities; the lower the score the more positive the attitudes are towards sexual minorities (Herek, 1998). Midscale scores indicate participants have more neutral attitudes regarding sexual minorities (Herek, 1998).

Some questions had an asterisk (*) beside them, and these were scored in reverse (Herek, 1998). Starred items on the ATL-S instrument were Items 1, 4, 5, 7, and 10. Question 7 states "Female homosexuality in itself is not problem, unless society makes it a problem" and Question 3 states "Female homosexuality is bad for society because it breaks down the natural divisions between the sexes." Starred items on the ATG-G instrument were Items 12, 14, 15, 18, and 20, and these items were scored as follows: 1 = 5, 4 = 2, 3 = 3, 2 = 4, and 5 = 1. Question 15 states "Male homosexuality is a natural expression of sexuality in men" and Question 17 states, "I would not be too upset if I learned that my son were a homosexual." The sums of items are divided by the total number of items derive a mean scale score (ATLG; Herek, 1988). I only computed means for participants who answered more than half of the items listed on each dependent measure. Herek (1998) suggested using both the ATG-S and the ATL-S to assess whether respondents have different attitudes towards gay men and lesbians.

The ATLG subscales demonstrated their validity through their association with other pertinent constructs (e.g., Herek, 1994, 2009; Herek & Capitanio, 1996, 1999a, 1999b) and also maintained high levels of internal consistency. This instrument was administered to a college student sample to examine its reliability and validity (Lance, 2002). Results indicated the alpha coefficients were found suitable and adequate for levels of internal consistency for the ATLG scale (Lance, 2002). I obtained permission to use this instrument (see Appendix B) and the complete instrument and instructions are located in Appendix C.

The Multicultural Counseling Knowledge and Awareness Scale

I used the MCKAS to measure the level of multicultural counseling skills within a counselor (see Ponterotto & Potere, 2003). The MCKAS that I used was a revision of the earlier Multicultural Counseling Awareness Scale (see Ponterotto & Potere, 2003). The MCKAS is a 32-item self-report inventory of perceived multicultural counseling knowledge and awareness (Ponterotto & Potere, 2003). It is a two-factor instrument that includes 20 knowledge items and 12 awareness items (Ponterotto & Potere, 2003). Awareness items are separated from the original 45-item listed on the MCKAS (Ponterotto & Potere, 2003).

The two-factor model is supported in both exploratory factor analysis and confirmatory factor analysis of the MCAS. Research on the MCKAS across multiple samples has shown the two factors to be internally consistent (Ponterotto & Potere, 2003). Coefficient alphas for the Knowledge scale clustered in the .92 range; and for the Awareness scale in the .78 range (Ponterotto & Potere, 2003). The MCKAS has been

used in various research and was proven to be a reliable instrument (Ponterotto & Potere, 2003). A study was conducted to explore multicultural competency amongst school counselors (Hays, 2008). Hays (2008) used the MCKAS to determine if there were a correlation between the counselor ability to counselor sexual minority having been training in multicultural competency. The results indicated school counselors who received training in multicultural awareness were more equipped to counsel sexual minorities (Hays, 2008).

The MCKAS awareness scale consists of 12 items 1, 4, 7, 10, 11, 18, 20, 24, 25, 26, 29, and 30. Of these items, the ten in parenthesis need to be reversed scored as follows: 1 = 7, 2 = 6, 3 = 5, 4 = 4, 5 = 3, 6 = 2, and 7 = 1. For example, Question 10 and Question 11 are awareness questions. Question 10 states, I think that clients should perceive the nuclear family as the ideal social unit. Question 11 states, I think that being highly competitive and achievement oriented are traits that all clients should work towards. The total mean score was divided by number of subscale items in the scale. Higher scores indicated more awareness of multicultural issues and lower scores indicated less awareness of multicultural issues.

The MCKAS knowledge scale consists of 20 items 2, 3, 5, 6, 8, 9, 12, 13, 14, 15, 16, 17, 19, 21, 22, 23, 27, 28, 31, and 32. For example, Question 12 and Question 30 are knowledge questions. Question 12 states, I am aware of the differential interpretations of nonverbal communication (e.g., personal space, eye contact, handshakes) within various racial/ethnic groups. Question 30, states I believe that all clients must view themselves as their number one responsibility. High scores indicated higher knowledge of multicultural

counseling and lower scores indicated less knowledge of multicultural counseling. The score range for the Knowledge scale using a mean score was derived by dividing the total score by the number of subscale items (Ponterotto & Potere, 2003). Permission was granted to use this instrument in located in Appendix D. The complete instrument and instructions are located in Appendix E.

Data Analysis Plan

For this study, the software package Statistical Package for the Social Sciences (SPSS) Version 21.0 for windows were used to analyze all data collected (Green & Salkind, 2012). SPSS is instantaneous in evaluating data and has engrained methods for data cleaning (Green & Salkind, 2012). The software also has a multiplicity of statistical diagrams, charts and tables in order to present findings from the data collected (Green & Salkind, 2012). I utilized descriptive statistics to analyze demographic items, frequency distributions for age, race, gender, how many years of experience, degree acquired, field of study, average number of patients seen per month and the number of patients who are identified themselves as sexual minorities per month. Each completed measure was reviewed for omitted data or empty responses within the data using SPSS Version 21.0. First, I checked the residuals errors of the regression line to see if they were normally distributed. Linearity and homoscedasticity were detected by creating and viewing a scatterplot. A Durbin-Watson statistic was used to determine independence, and a P-P plot was examined to test for normality of residuals (Tabachnick & Fidell, 2007 & 2013).

For this study, hierarchical linear regression analysis was used in which linear regression calculates an equation that minimizes the distance between the fitted line and

all of the data points (Tabachnick & Fidell, 2007; 2013). Regression analyses required me to look at four principal assumptions: normality, linearity, homoscedasticity and independence (Tabachnick & Fidell, 2007; 2013). When the assumptions were met, a hierarchical multiple regression analysis was conducted. Main effects were entered into the regression equation on the first step. This included race (0 = Non-White; 1 = White), gender (0 = females; 1 = males). The scores were centered and the mean score was subtracted from every individual score. The inclusion of main effects on Step 1 of the regression equation addressed Research Questions 1 and 2. On the second step, I entered the interaction terms for race and multicultural awareness and for gender and multicultural awareness. These interaction terms were computed by multiplying the centered MCKAS scores and the race and gender codes described above. These interactions tested the hypothesis that counselor multicultural awareness moderates the association of counselor race/gender with attitudes towards sexual minorities. On each of these steps, I examined the overall R-squared for significance and when it showed significant, I then examined the individual predictors that was entered on this step. The results indicated in the findings that Cronbach's alpha scores for multicultural counseling knowledge and awareness was .77 for knowledge, and .92 for awareness. Cronbach's alpha value for attitudes lesbian and gay men were both .73. The results for the entire Cronbach's alpha score for the instrument was a score of .78.

The following research questions and hypotheses were investigated in the proposed study were:

Research Question 1: Is counselor gender associated with attitudes toward sexual minorities?

$H_0$1: Counselor gender was not associated with attitudes towards sexual minorities.

$H_1$1: Counselor gender was associated with attitudes toward sexual minorities.

Research Question 2: Is counselor race associated with attitudes toward sexual minorities?

$H_0$2: Counselor race was not associated with attitudes towards sexual minorities.

$H_1$2: Counselor race was associated with attitudes towards sexual minorities.

Research Question 3: Does counselor multicultural competency moderate the association of counselor race or gender with attitudes towards sexual minorities?

$H_0$3: Counselor multicultural competency did not moderate the association of race or gender with attitudes towards sexual minorities.

$H_1$3: Counselor multicultural competency did moderate the association of race or gender with attitudes towards sexual minorities.

Threats to Validity

As with any study, there are threats to validity and internal validity that can inhibit a researcher from adequately replicating successful results done in a study (Babbie, 2007). Threats to validity must be addressed to ensure the validity of study and

if attention is given to the validity and reliability during the study, threats can be diminished greatly (Babbie, 2007). Internal validity may be threatened if participants who are participating skip questions, rush through the survey, or do not fully read the questions (Babbie, 2007). To reduce non-response bias, participants were given the opportunity to start, stop, and save the survey as many times as they needed to in order to finish survey at their convenience (West & Little, 2013).

Another validity threat that can affect this study is social desirability bias. Social desirability bias refers to the idea that persons taking surveys tend to answer questions in a way that was be looked at as positive by others (Ganster, Hennessey & Luthans, 1983) In other words, when individuals are giving details about themselves regarding intimate or delicate information, human beings tend to respond to inquiries in a socially suitable way (Ganster et al., 1983). On my contest form I asked all participants to be honest and clear about their answers by reiterating that their answers are completely anonymous. Even though there are many threats that can affect the validity of this study, I took the necessary precautions by clearly defining Research questions and I used an appropriate research design to address Research questions.

Self-selection bias is another concern that can affect this research. This is a situation where individuals place themselves into a group based on their personal thoughts and objectives which can create a biased sample (Jacobs, Hartog & Vijverberg, 2009). Limited generalizability was another concern that was addressed in this study. Due to the fact, that this study included licensed counselors who are members of the ACA, Walden University Participant Pool and Licensed counselors registered with Exact Data

findings this study was limited to these members only. A list of requirements were included in the invitation asking participants to read them thoroughly to make sure they qualify to take the study before participating in this study.

Ethical Procedures

All surveys were created using Survey Monkey which was completely anonymous. Before any data was collected, this study was approved by Walden University's IRB board (06-09-16-00017515). After approval data were collected using online surveys hosted using Survey Monkey. The target population was licensed counselors who are active members of the (ACA), Walden University Participant Pool and Licensed counselors registered with Exact Data. The informed consent to participate in the online survey was hosted on the ACA website, hosted on Walden University Participant Pool and e-mails were sent to licensed counselors who were registered with Exact Data. All participants were provided with an informed consent that described the study procedures as well as the risks and benefits of participation in this study. Participants checked a box with indicated they had read the consent form and agreed to the terms to take the survey. The consent form clearly stated the inclusion and exclusion specifications with hopes it prevented unqualified participants from taking the study. Participants were able to stop in the process, with no consequences for not completing this study. A resource list was provided to all participants in the event any concerns arise after taking the survey was included on the informed consent. To assess the resource list, participants were told to copy and paste the link into their browser. After the surveys were completed all data were sent to me using Survey Monkey. Survey Monkey has

inbuilt security checks to ensure anonymity, privacy and confidentiality of participants by using Secure Sockets Layer (SSL) encryption technology (Survey Monkey, 2014). I download results from this study on a password protected flash drive.

Summary

Within this chapter, a detailed description of this quantitative study examining counselors' attitude, counselor's gender, counselors' race and multicultural competency were presented. Three research questions were introduced, validity issues of the research method and ethical concerns of the data collection process were also addressed. In this chapter, the instruments that were used to measure the dependent and independent variables (predictor) were presented. Processes for interpretation of research results, regression and probability estimates were addressed were also addressed in Chapter 3. Chapter 4 gave detailed information about the results of the study.

Chapter 4: Results

Introduction

Research implies that negative homophobic viewpoints can be a concern when performing clinical work with sexual minorities (Morrow & Messinger, 2006). Counselors are trained to acknowledge and accept diversity; however, some evidence indicates that prejudice towards sexual minorities still occurs (Swank & Raiz, 2010). Although sexual minorities tend to bring the same issues as their heterosexual peers into therapy (e.g., mental health issues, substance abuse, relationships, etc.), counselors may need to diminish their heterosexism and/or heterosexual bias towards sexual minorities (Swank & Raiz, 2010). In this chapter, I will present the outcomes of this study in which I examined the extent that counselor gender, race, and multicultural competency skills are associated with homophobic attitudes when counseling gay and lesbian clients. I will also review the findings within the context of the research questions and objectives.

Research Questions and Hypotheses

In this study, I examined the criterion (dependent variable) of counselor's attitude toward sexual minorities and the three predictors (independent variables) of gender, race, and multicultural competency. The research questions and hypotheses developed for this study were:

Research Question 1: Is counselor gender associated with attitudes toward sexual minorities?

$H_0$1: Counselor gender was not associated with attitudes towards sexual minorities.

$H_1$1: Counselor gender was associated with attitudes toward sexual minorities.

Research Question 2: Does counselor race moderate the association of counselor's multicultural competency with attitudes towards sexual minorities?

$H_0$2: Counselor race did not moderate the association of multicultural competency with attitudes towards sexual minorities.

$H_1$2: Counselor race did moderate the association of multicultural competency with attitudes towards sexual minorities.

Research Question 3: Does counselor multicultural competency moderate the association of counselor race or gender with attitudes towards sexual minorities?

$H_0$3: Counselor multicultural competency did not moderate the association of race or gender with attitudes towards sexual minorities.

$H_1$3: Counselor multicultural competency did moderate the association of race or gender with attitudes towards sexual minorities.

Test of Survey

After receiving my approval from IRB on June 9, 2016 to start collecting data, I created a Survey Monkey account and created my surveys using items and responses from the approved measures. Responses in Survey Monkey were set so there could only be one survey taken per computer and only one survey taken per e-mail address. The survey instrument I created in Survey Monkey was reviewed by my dissertation committee and after making several sentence changes for clarity, I then posted my invitation to participate in my study to my target population.

Data Collection

Starting on July 2, 2016 until October 14, 2016, I posted an invitation and provided a link to my study on the ACA website. After 3 months, only two participants took my study. Therefore, I submitted a change of procedure to Walden University's IRB board to increase the number of participants in my study by adding Walden's Participant Pool on October 14, 2016. I received notification from Walden's IRB board that my request was granted on October 24, 2016. Only two individuals participated in my study from the Walden Participant Pool. I submitted another change in procedures to Walden's IRB Board to increase the number of participants to take my study asking for permission to purchase e-mail addresses from Exact Data. Exact Data is an organization that complies professional email lists. Individual on these lists must have acquired an undergraduate degree up to a doctorate degree and hold a licensure or certificate in their field of study. Exact Data is based in Chicago, Illinois and operates in 2 countries and caters to individuals and businesses nationwide. Once you pay for the e-mails, they are sent to your email address and no names are associated. If you need to purchase more e-mails, you can go back into the website sign in and purchase them as needed. On April 24, 2017, I received notification from Walden's IRB that my request was approved to purchase e-mail lists of professional counselors registered with Exact Data. I sent out e-mail recruiting participants to all 1,000 e-mail addresses on the list I received from Exact Data on July 8, 2017, and I sent survey reminders every 3 days until August 10, 2017. Out of the 1,000 e-mails that were sent out, only 36 participants took my study, making a total of 40 participants.

Descriptive Statistics

The majority of the participants who took this study were between 30–40 years of age. More White people participated in this study than non-White people. More women than men participated, and more counselors with 10 or more years of experience than counselors with less experience. In the field of study category, the majority of the participants were mental health counselors. Table 1 presents descriptive statistic for other demographic variable collected in this study.

Table 1 Charactertics of the Sample

Charactertics of the Sample

Variable	*N*	Category	Frequency	Percent
Age	40	18–29 years	2	15.0
		30–40 years	12	30.0
		41–50 years	10	25.0
		51–60 years	6	15.0
		61–70 years	3	7.5
		Over 70 years	1	2.5
Race/ethnicity	40	White	20	58.8
		Non-White	14	41.2
		Race/ethnicity not listed	0	0
Gender identity	40	Woman	29	72.5
		Man	11	27.5
		Transman	0	0
		Transwoman	0	0
		Genderqueer/gender	0	0
		Gender not listed	0	0
Sexual orientation	40	Heterosexual	37	92.5
		No response	3	7.5

(table continues)

Variable	*N*	Category	Frequency	Percent
Years of experience	40	3 years	3	7.5
		4–6 years	7	17.5
		7–9 years	7	17.5
		10 years or above	17	42.65
Field of study	40	Psychologist	3	7.5
		Career counselor	1	2.5
		Guidance counselor	0	0
		School counselor	8	22.0
		Mental health counselor	11	27.5
		Addiction/substance abuse	3	7.5
		Social worker	5	12.5
Counselor not listed		Behavioral counselor	1	2.5
		Clergy	1	2.5
		Addiction/substance abuse	3	7.5
Degree acquired	40	Bachelor’s degree	1	2.5
		Master’s degree	29	72.5
		Doctorate	10	25.0
Average # of patients seen per month	40	0–5 patients	1	2.5
		6–10 patients	5	12.5
		11–15 patients	9	22.5
		16–20 patients	2	5.0
		Over 20 patients	17	46.5
Degree acquired	40	Bachelor’s degree	1	2.5
		Master’s degree	29	72.5
		Doctorate	10	25.0
Average # of patients seen per month	40	0–5 patients	1	2.5
		6–10 patients	5	12.5
		11–15 patients	9	22.5
		16–20 patients	2	5.0
		Over 20 patients	17	46.5

(table continues)

Variable	*N*	Category	Frequency	Percent
Average # of patients who identified themselves as a sexual minority	40	0-5	22	55.0
		6-10	1	2.5
		11-15	2	5.0
		16-20	1	2.5
		I don't know	3	7.5

The means and standard deviation indicated in Table 2 show that the mean score was higher for attitudes toward gay men than the score towards lesbians.

Table 2 Means, Standard Deviation

Mean (*M*), *Standard Deviation* (*SD*), *and 95% CIs*

Variable	*M*	*SD*	*SD* 95% *CI* Lower	Upper
Multicultural knowledge and awareness	175.11	18.95	12.50	23.88
Knowledge	113.1	14.9	106.8	118.5
Awareness	56.5	19.5	49.0	63.8
Attitudes toward lesbian and gay men	56.12	6.12	3.78	7.97
Attitude toward lesbians	24.96	7.24	3.51	9.55
Attitudes toward gay men	31.09	2.73	1.75	3.40

Note. *N* = 40. Means (*M*), standard errors (*SE*), and 95% *CIs* are based on 1,000 bootstrap samples.

Inferential Results

I employed hierarchical linear regression to examine the associations among counselor's race, gender, multicultural competency, and attitudes towards sexual minorities. The predictors (independent variables) were counselor's gender, race, and multicultural competency. The criterion (dependent variable) was defined as the counselors' attitudes toward sexual minorities. Additionally, my analysis examined whether multicultural competency moderated any associations of gender and race with

attitudes towards sexual minorities. The assumptions of outliers, normality, linearity, homoscedasticity, and independence of residuals were assessed, with violations noted (see the following Test of Assumptions section). Therefore, I reported bootstrapping 95% CIs to combat any possible influence of assumption violations.

Test of Assumptions

An assessment of the normality of data was a prerequisite for this study because I used methods of evaluating normality by incorporating graphs. The assumptions that I tested surrounded the regression which assessed the visual inspection of the normal probability (P-P) plot of the regression residual (see Figure 1). Failure of the residuals to lie in a straight-line parallel to the predicted values is evidence of violation of the normality assumption (Tabachnick & Fidell, 2007; 2013). I used power analyses through G*Power 3.1 for a hierarchical linear multiple regression to determine a sample size of 77 participants (Faul et al., 2009). However, due to recruitment problems the sample size used for this study was only 40 participants.

I used a statistical technique called bootstrapping because of the small sample size. Bootstrapping was also used to test bias, variance, and prediction error (see Yung & Bentler, 1996). Incorporating bootstrapping gave an approximation of the sample distribution with replacement from the sample data to create a large number of samples (see Yung & Bentler, 1996). Bootstrapping is a computer-based method used through SPSS for assigning measures of accuracy to statistical estimates (Forstmeier, Wagenmakers, & Parker, 2016). Using this technique allowed me to get a good estimation of the sampling distribution which furthermore allowed the use of

resampling methods (see Forstmeier et al., 2016). A low statistical power lowered the ability of finding a true effect, but bootstrapping was utilized to govern and check the stability of the results (see DiCiccio & Efron, 1996). Therefore, I computed 1,000 bootstrapping samples and appropriate 95% CIs were reported to combat possible implications of assumption violations (see Mooney, Christopher, & Duval, 1993). Even with a large sample, it is not possible to know the exact confidence interval, but bootstrapping is asymptotically more precise than the standard intervals achieved using sample variance and assumptions of normality (Beran, 1990). If I were analyzing data with larger samples, I would have looked at assuming a normal distribution or a *t* distribution, but instead I used the statistical sample from the population I had collected. A 90% CI made bootstrapping easy to use since bootstrapping does not require anything other than the sample itself (see Yung & Bentler, 1996). The histogram in Figure 2 further supports the tenability of normality assumption violation. The scatterplot of the residual (see Figure 3) suggested violation of the homoscedasticity assumption and increasing variance across the residuals.

Figure 1. Normal probability plot of the standardized residuals.

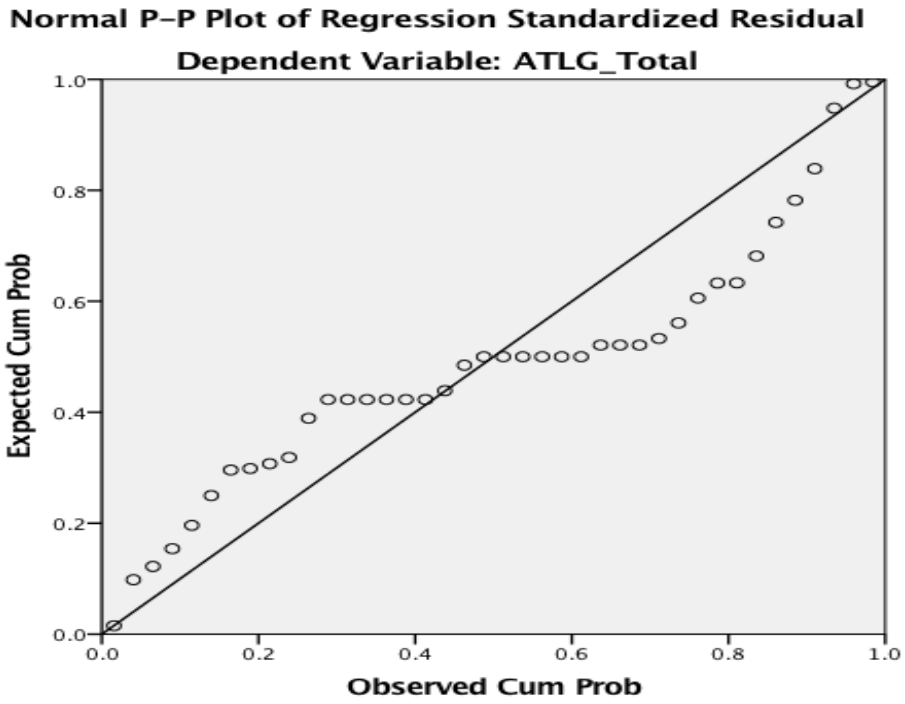

Figure 2. Histogram of regression standardized residuals.

Figure 3. Scatterplot of the regression residuals.

Hierarchical linear multiple regression was used to test hypotheses. A Hierarchical linear regression, a = .05, (two-tailed) was employed to examine the associations among counselors' race, gender, multicultural competency and attitudes towards sexual minorities. Moderating effects of multicultural competency and race, and multicultural competency by gender on counselor's attitudes toward sexual minorities were also assessed. I generated a scatterplot looking for curves or skewness in the data set and assumption were tested and violation noted.

Gender and race was combined in Step 1 and results were broken down in chart. Step 2 multicultural competency by race and gender was entered looking at both variables race and gender using the MKCAS scale. Race and gender were entered at Step

1; the results were not statistically significant. The interaction terms, multicultural competency and race, and multicultural competency by gender were entered in Step 2; again, the results were not statistically significant. Therefore, the null hypotheses that counselor gender would not be associated with attitudes towards sexual minorities, counselor race would not be associated with attitudes towards sexual minorities, and counselor multicultural competency would not moderate the association of race or gender with attitudes towards sexual minorities were maintained. There were no association among the predictor, moderator, and dependent variables.

Research Question 1. Gender was entered at Step 1, explaining 3% of the variance in counselors' attitudes towards sexual minorities. However, the results were not statistically significant $F(2, 18) = .372$, $p = .695$, indicating the main effect model was not able to significantly predict counselors' attitudes towards sexual minorities.

Research Question 2. Race was entered at Step 1, also explaining 3% of the variance in counselors' attitudes towards sexual minorities. However, the results were not statistically significant. In Step 2, after entry of the interaction term, the model was able to explain less than 1% of the variance ($R^2 = .006$). Race did not have any mediating effect.

Research Question 3. The interaction terms, multicultural competency by race, and multicultural competency by gender were entered in Step 2. The results were not statistically significant $F(4, 16) = .189$, $p = .940$, indicating multicultural competency did not moderate the relationship between race, gender, and counselors' attitudes towards sexual minorities.

Table 3 Hierarchical Regression Analysis Summary for Variables Predicting Counselor Attitudes toward Sexual Minorities

Hierarchical Regression Analysis Summary for Variables Predicting Counselor Attitudes toward Sexual Minorities

Step and predictor variable	*B*	*SE B*	*p*	*B* 95% *CIs* Lower	Upper
Step 1					
Race	-3.125	4.098[a]	.471[b]	-11.210[b]	4.791[a]
Gender	1.000	2.328[a]	.701[b]	-3.772[b]	5.124[a]
Step 2					
Race	-2.998	40.382[b]	.912[b]	-76.670[b]	74.205[b]
Gender	10.877	43.24[b]	.738[b]	-70.37[b]	87.348[b]
MKCAS by Race	0.001	.227[b]	1.000[b]	-.436[b]	.424[b]
MKCAS by Gender	0.060	.245[b]	.750[b]	-.507[b]	.375[b]

a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

Summary

All three research questions were examined and results indicated in Research Question 1 that there was no significant predictors when examining counselors' attitudes towards sexual minorities. Research Question 2 indicated when looking at race, that **r**ace did not have any mediating effect. Research Question 3. The results were not statistically significant indicating multicultural competency did not moderate the relationship between race, gender, and counselors' attitudes towards sexual minorities.

Hierarchical linear regression was employed to examine the associations among counselors' race, gender, multicultural competency and attitudes towards sexual minorities. Moderating effects of multicultural competency on race and gender on counselors' attitudes toward sexual minorities were non-significant. 1,000 bootstrapping

samples were computed and appropriate 95% *CI*s were reported. Race and gender were entered at Step 1 to test Research Question 1; the results were not statistically significant. The interaction terms, multicultural competency and race, and multicultural competency by gender were entered in Step 2 to test both Research Question 2 and Research Question 3. The results were not statistically significant. Therefore, the null hypotheses were maintained for each of the three research questions. Chapter 5 provided interpretation of results, comparison of questionnaire to literature, comparison of results to the literature, relevance to theoretical framework, implications for social change, limitations of study, and directions for future research.

Chapter 5: Discussion

Introduction

I conducted a quantitative study to determine the relationship between counselors' race, gender, multicultural competency, and attitudes towards sexual minorities. In addition, I examined whether multicultural competency moderated the relationship between counselors' gender and race when counseling sexual minorities. The theoretical foundation of my study was built upon the multicultural competency theory (see Sue et al., 1996), which suggested undesirable attitudes about others may surface in counseling sessions when counselors are not adequately prepared to engage in multicultural interactions. Sue et al. (1996), clearly indicated that this is a necessary skill for counselors to attain and acquire. When multicultural competency is in place and functionally properly, counselors have the increased knowledge, skills, and experience required to give clients the best care (Sue, et al., 1996). I incorporated hierarchical linear regression to examine the relationship between counselors' race, gender, multicultural competency and attitudes concerning sexual minorities. After all, three research questions were examined some of the key findings indicated there was no significant indicators when observing counselors' attitudes towards sexual minorities based on the race and gender of the counselor.

Interpretation to Findings

Counselors' race and gender were not significant predictors of their attitudes toward sexual minorities, contrary to my hypotheses. The results from this study indicated it was important to formulate questions that need further investigation in order

to address counselors' attitudes based on race, gender, and multicultural competency when counseling sexual minorities. Findings in existing literature indicated homophobic attitudes play a major role in the treatment and actions displayed against sexual minorities (Sue & Sue, 2013). Counselor biases and preconceptions need to be addressed to prevent harmful aftereffects that sexual minorities may be subjected to in the counseling environment (Sue & Sue, 2013). Multicultural competency is designed to assist counselors with their repertoire of skills, which may help counselors be aware of intentional and negative attitudes toward gay men and lesbians (Sue et al., 1996). Findings in literature indicated that counselor education programs train counselors to guide clients in accordance with their professional ethical responsibilities (Tao, Owen, Pace, & Imel, 2015). In another study, researchers found that the education counselors have on multicultural training allows them to face issues of race, culture, and social barriers that they encounter with diverse clients (Wendt, Gone, & Nagata, 2015).

There is no research that suggests there should not be an effect, so the lack of significance found in this study may be due to small sample size, which is known to present threats to validity (see Button et al., 2013). Also, missing data are ubiquitous and if data are missing, variables are referred to as suppressed, leading to a loss of statistical power (Button et al., 2013). Results of this study also indicated that multicultural competency was not significant when counseling sexual minorities. Multicultural competency is a tool that helps counselors understand diversity, and it is important to continue to educate counselors so they are aware of biases that can exist when counseling sexual minorities (Sue & Sue, 2013).

Limitations of the Study

The limitations to this study that I identified stemmed from the fact that the sample included licensed counselors from the ACA, Walden University's Participants Pool, and licensed counselors registered with Exact Data. In this study, participants were recruited using a voluntary sample, so generalizability was a major concern. In this study, I incorporated groups that were similar to the variables, and they were clearly defined in order to prevent error; however, the sample size and recruitment challenges were a major threat that affected the external validity (see Compeau, Marcolin, Kelly, & Higgins, 2012). When the sampling procedures were implemented in this study there was a chance the external validity was affected causing no significant findings between variables (see Marcellesi, 2015). External validity is related to generalizing which refers to the approximate truth of propositions, inferences, or conclusions (Bareinboim & Pearl, 2013; Pearl, 2015).

Recommendations for Future Research

I recommend that future research consider different methods. For instance, the population in this study was defined as heterosexual counselors and future studies could include a broader set of sexual orientations. Conducting site visits to discuss the study with counselors at different clinics, hospitals, or treatment facilities may encourage more participants to take the study. Because I examined multicultural competency in this study, an intervention could have been administered which would allow assessment of counselors' attitudes before and after the intervention. Also, based on the power analyses to compute a priori sample size for this study, conducting a hierarchical linear multiple

regression based on G*Power 3.1 with an effect size of 0.15, an error probability of 0.05, and power of 0.80, the estimated total sample size was 77 participants (Faul et al., 2009). I would suggest obtaining at least 77 participants to take this study. After a year and a half of collecting data, only 40 participants took my study, allowing this study a very small sample size.

Other future research that is important to consider is that of sexual minorities among members of the teaching profession. Educators, tutors, and instructors in the United States tend to be held to a higher level of expectancy of adapting to society norms than the average citizen (DeMitchell, Eckes, & Fossey, 2009). Looking at the social norms of teachers is important when looking at the skills necessary to work effectively in a diverse teaching environment (Bezrukova, Spell, Perry, & Jehn, 2016). For example, a study of 260 teachers assessed training about diversity and this study found that students had undesirable, unconstructive, and disapproving attitude toward teachers who were homosexual (Bezrukova et al., 2016). Whether it is behavior, appearances, personality differences, or other factors, any deviation from the conventional norm can led to negative consequences ranging from oral reprimands, warnings, or unemployment amongst homosexual teachers (Khan & Gorski, 2016). Researchers Gorski, Davis, and Reiter (2013), found that experience and the ability of the teacher was not important because some students were more concerned with the teacher's sexual orientation than their knowledge as a teacher. Similarly, in another study, researchers found heterosexism against lesbian, gay, bisexual, and transgender (LGBTQ) teachers was prevalent and caused negative attitudes towards LGBTQ teachers (Paparo & Sweet, 2014). In a

different study about training for diversity and teaching, the results showed students had a negative attitude toward teachers who were homosexual (Kull, Greytak, Kosciw, & Villenas, 2016). However, when ddiversity programs were introduced, there was unquestionable positive aftereffects on students when they completed diversity programs where both awareness and skills development were added (Kull, et al., 2016). Lastly, heterosexism has been a major concern for LGBTQ teachers. When diversity programs were introduced, students began to report positive attitude towards this group of educators (Khan & Gorski, 2016).

Implications for Social Change

The results of this study were not significant so this made it difficult to come to conclusions about the associations between counselor factors (i.e., race, gender, and multicultural competency) and attitudes toward sexual minorities. The social change impact of this study is to look at the idea of gaining adequate skills to promote knowledge in the field of counseling. The goal of this work was to facilitate positive social change by explicating a supportive environment for sexual minorities seeking counseling (see Hazler & Wilson, 2010). By sharing these results at professional conferences and meetings, I hope that the results will help sexual minorities feel comfortable when counseling is needed. Related work in the field of counseling of sexual minorities pertains to heterosexual allies. Even though only a handful of studies have methodically examined the development of heterosexual allies, researchers have indicated heterosexual allies may provide a vital and essential role in reducing sexual prejudice by against sexual minorities (Duhigg, Rostosky, Gray, & Wimsatt, 2010). Consequently,

designing programs to assist counselors with diversity training might increase competent practices with counseling professionals. The integration of diversity in the curricula for counselors in training can support the growth of multicultural competency (Duhigg et al., 2010).

Conclusions

My aim with this investigation was to examine the extent to which a counselor's attitude toward sexual minorities is affected by race, gender, and multicultural competency when counseling sexual minorities. In addition, I used multicultural competency theory to describe how counselor attitudes affect the counseling environment. This theory was incorporated into this study to illustrate the dynamics of counseling sexual minorities. The key findings of my study were that there were no significant factors in relation to race, gender, or multicultural competency as they pertain to the counseling of sexual minorities because all results were not significant.

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Appendix B: Written Permission to Use Scale: Attitudes Towards Lesbian and Gay Men

Doctoral-level social and behavioral scientists, as well as students and researchers working under their supervision, may use the ATLG in not-for-profit research that is consistent with the American Psychological Association's Ethical Principles of Psychologists. It is not necessary to obtain formal permission from Dr. Herek to use the scale in research that meets these conditions, and such permissions are not provided, even upon request. Permission to use the scale is explicitly denied to individuals who have been expelled or dropped from membership in a professional or scientific association because of their violation of the organization's ethical standards.

Appendix C: Attitudes Toward Lesbian and Gay Men Scale

Please indicate your level of agreement with the items below using the following scale:

1 = strongly disagree
2 = disagree
3 = neither agree or disagree
4 = agree somewhat
5 = strongly agree

ATL (Attitudes toward Lesbians)
1. Lesbians just can't fit into our society*
2. A woman's homosexuality should not be a cause for job discrimination in any situation
3. Female homosexuality is bad for society because it breaks down the natural divisions between the sexes.
4. State laws regulating private, consenting lesbian behavior should be abolished.*
5. Female homosexuality is a sin.*
6. The growing number of lesbians indicates a decline in American morals.
7. Female homosexuality in itself is not problem, unless society makes it a problem.*
8. Female homosexuality is a threat to many of our basic social institutions.
9. Female homosexuality is an inferior form of sexuality.
10. Lesbians are sick*

ATG (Attitude Towards Gays)
11. Male homosexual couples should be allowed to adopt children the same as heterosexual couples.
12. I think male homosexuals are disgusting.*
13. Male homosexuals should not be allowed to teach school.
14. Male homosexuality is a perversion. *
15. Male homosexuality is a natural expression of sexuality in men. *
16. If a man has homosexual feelings, he should do everything he can to overcome them.
17. I would not be too upset if I learned that my son were a homosexual. *
18. Sex between two men is just plain wrong. *
19. The idea of male homosexual marriages seems ridiculous to me.
20. Male homosexuality is merely a different kind of lifestyle that*

Starred (*) items (1, 4, 5, 7 10 (ATL-S) and starred (*) items (12, 14, 15, 18, 20 (ATG-S) are scored in reversed.

Appendix D: Written Permission to Use Scale: Multicultural Counseling Knowledge and Awareness Scale

Dear MCKAS User:

Enclosed is the MCKAS, scoring directions, and the "Utilization Request Form" which must be carefully read, endorsed, and returned prior to MCKAS use.

Please note that the development and initial validity studies on the MCKAS (originally titled the MCAS) were published as a lengthy chapter in the following book:

Ponterotto, J.G. et al., (1996). Development and initial validation of the Multicultural Counseling Awareness Scale. In G.R. Sodowsky & J.C. Impara (Eds.), Multicultural assessment in counseling and clinical psychology (pp. 247-282). Lincoln NE: Buros Institute of Mental Measurements.

The book can be ordered through Buros by calling 402-472-6203; or by writing to Buros Institute of Mental Measurements, Department of Educational Psychology, 135 Bancroft Hall, University of Nebraska, Lincoln, NE 68588-0348.

The revised MCKAS is presented in:

Ponterotto, J.G., Gretchen, D., Utsey, S. O., Riger, B. P., & Austin, R. (2002). A revision of the multicultural counseling awareness scale. Journal of Multicultural Counseling and Development, 30, 153-181.

The latest presentation, critique, and user guidelines for the MCKAS is presented in: Ponterotto, J. G., & Potere, J. C. (2003). The Multicultural Counseling Knowledge and Awareness Scale (MCKAS): Validity, reliability, and user guidelines. In D. P. Pope-Davis, H. L. K. Coleman, W. M. Liu, & R. Toporek (Eds), Handbook of multicultural competencies in counseling and psychology (pp. 137-153). Thousand Oaks, CA: Sage. (Any user of the MCKAS must read this source.)

Critical reviews of the MCAS/MCKAS and other multicultural competency measures can be found in: Constantine, M. G., & Ladany, N. (2001). New visions for defining and assessing multicultural counseling competence. In J.G. Ponterotto, J.M. Casas, L.A. Suzuki, & C.M. Alexander (Eds.), Handbook of multicultural counseling (2nd ed., pp. 482-498). Thousand Oaks, CA: Sage Publication.

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Appendix E: Multicultural Counseling Knowledge and Awareness Scale

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

1. I believe all clients should maintain direct eye contact during counseling.
1 2 3 4 5 6 7

2. I check up on my minority/cultural counseling skills by monitoring my functioning – via consultation, supervision, and continuing education.
1 2 3 4 5 6 7

3. I am aware some research indicates that minority clients receive "less preferred" forms of counseling treatment than majority clients.

1 2 3 4 5 6 7

4. I think that clients who do not discuss intimate aspects of their lives are being resistant and defensive.

1 2 3 4 5 6 7

5. I am aware of certain counseling skills, techniques, or approaches that are more likely to transcend culture and be effective with any clients.

1 2 3 4 5 6 7

6. I am familiar with the "culturally deficient" and "culturally deprived" depictions of minority mental health and understand how these labels serve to foster and perpetuate discrimination.

1 2 3 4 5 6 7

7. I feel all the recent attention directed toward multicultural issues in counseling is overdone and not really warranted.
1 2 3 4 5 6 7

8. I am aware of individual differences that exist among members within an ethnic group based on values, beliefs, and level of acculturation.

1 2 3 4 5 6 7

9. I am aware some research indicates that minority clients are more likely to be diagnosed with mental illnesses than are majority clients.
1 2 3 4 5 6 7

10. I think that clients should perceive the nuclear family as the ideal social unit.
1 2 3 4 5 6 7

11. I think that being highly competitive and achievement oriented are traits that all clients should work towards.
1 2 3 4 5 6 7

12. I am aware of the differential interpretations of nonverbal communication (e.g., personal space, eye contact, handshakes) within various racial/ethnic groups.
1 2 3 4 5 6 7

13. I understand the impact and operations of oppression and the racist concepts that have permeated the mental health professions.
1 2 3 4 5 6 7

14. I realize that counselor-client incongruities in problem conceptualization and counseling goals may reduce counselor credibility.
1 2 3 4 5 6 7

15. I am aware that some racial/ethnic minorities see the profession of psychology functioning to maintain and promote the status and power of the White Establishment.
1 2 3 4 5 6 7

16. I am knowledgeable of acculturation models for various ethnic minority groups.
1 2 3 4 5 6 7

17. I have an understanding of the role culture and racism play in the development of identity and worldviews among minority groups.
1 2 3 4 5 6 7

18. I believe that it is important to emphasize objective and rational thinking in minority clients.
1 2 3 4 5 6 7

19. I am aware of culture-specific, that is culturally indigenous, models of counseling for various racial/ethnic groups.
1 2 3 4 5 6 7

20. I believe that my clients should view a patriarchal structure as the ideal.
1 2 3 4 5 6 7

21. I am aware of both the initial barriers and benefits related to the cross-cultural counseling relationship.
1 2 3 4 5 6 7

22. I am comfortable with differences that exist between me and my clients in terms of race and beliefs.
1 2 3 4 5 6 7

23. I am aware of institutional barriers which may inhibit minorities from using mental health services.
1 2 3 4 5 6 7

24. I think that my clients should exhibit some degree of psychological mindedness and sophistication.
1 2 3 4 5 6 7

25. I believe that minority clients was benefit most from counseling with a majority who endorses White middle-class values and norms.
1 2 3 4 5 6 7

26. I am aware that being born a White person in this society carries with it certain advantages.
1 2 3 4 5 6 7

27. I am aware of the value assumptions inherent in major schools of counseling and understand how these assumptions may conflict with values of culturally diverse clients.
1 2 3 4 5 6 7

28. I am aware that some minorities see the counseling process as contrary to their own life experiences and inappropriate or insufficient to their needs.
1 2 3 4 5 6 7

29. I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.
1 2 3 4 5 6 7

30. I believe that all clients must view themselves as their number one responsibility.
1 2 3 4 5 6 7

31. I am sensitive to circumstances (personal biases, language dominance, stage of ethnic identity development) which may dictate referral of the minority client to a member of his/her own racial/ethnic group.
1 2 3 4 5 6 7

32. I am aware that some minorities believe counselors lead minority students into non-academic programs regardless of student potential, preferences, or ambitions.
1 2 3 4 5 6 7

Appendix F: Demographic Survey

1.Age: Please select age (if over 70 write age in)
1= 18-29
2= 30-40
3= 41-50
4= 5-60
5= 61-70
6= Over 70: _____

2.Race
1= Black/African American
2= Native American or Alaskan native
3= Hawaiian or Pacific Islander
4= White/Caucasian
5= Hispanic or Latino/a
6= Asian or Asian American or
7= Race/ethnicity not listed

3.Gender
1= Woman
2= Man
3= Transman
4= Transwoman
5= Genderqueer/gender non-conforming
6= Gender not listed (Please write in: _____)

4.Degree Acquire
1= Bachelor Degree
2= Master's Degree
3= Doctorate Degree

5.Field of Study
1= Social worker
2= Psychologist
3= Career counselor
4= Guidance counselor
5= School counselor
6= Mental health counselor
7= Addiction/substance counselor
8= Other counselor (Please write in: _____)

6.The Average Number of Patients Seen Per Month: (0-20)
1= 0-5
2= 6-10
3= 10-15
4= 15-20
5= 20 or more

7.The average number of patients who have identified themselves as a sexual minority seen per month:
0-20).
1= 0-5
2= 6-10
3= 11-15
4= 16-20
5= 20 or more
6= “I don’t know” as a response